OUR LADY OF THE LAKE PHYSICIAN GROUP

Surgeons Group of Baton Rouge
7777 Hennessy Blvd. Ste. 612
Baton Rouge, La 70808
225-769-5656
225-769-7271 (fax)

BARIATRIC QUESTIONNAIRE

Name_____ Date_____

Address_____

Date of Birth_____ Age _____Sex _____ Race_____

Home #_____Work # _____

Cell #_____ Email Address_____

PROCEDURE

- ☐ Roux-en-Y Gastric Bypass
- ☐ Sleeve Gastrectomy
- ☐ Duodenal Switch
- ☐ Gastric Revision
- ☐ Endoscopic Sleeve Gastroplasty
- ☐ Orbera Gastric Balloon

PHYSICIAN

- ☐ Karl A. LeBlanc, M.D., MBA, FACS
- ☐ Mark G. Hausmann, M.D., FACS
- ☐ Kenneth P. Kleinpeter, Jr., M.D., FACS
- ☐ Brent W. Allain, Jr., M.D.

FACILITY

- ☐ Our Lady of the Lake Regional Medical Center
- ☐ Woman's Hospital

_____Height

_____Weight

_____BMI (we will calculate this for you)

* **Have you attended a seminar?** ☐ Yes ☐ No

* **Which seminar?** ☐ OLOL ☐ Other: _____

How did you hear about the doctors of The Surgeons Group of Baton Rouge?

- ☐ Seminar- ☐ OLOL ☐ Other: _____ _____
- ☐ Television
- ☐ Business Report/Daily Report
- ☐ Web:_____
- ☐ Referral from a Doctor
  Which physician? _____
- ☐ Referred by existing patient
  Which patient? _____
- ☐ Radio (Which Station?)_____
- ☐ Advocate
- ☐ Yellow Pages
- ☐ Other: _____

In the spaces provided below, please completely answer all questions to the best of your ability.

HAVE YOU EVER HAD ANY ABDOMINAL SURGERIES?
☐ Yes ☐ No

IF YES, EXPLAIN BELOW (TYPE OF SURGERY, DOCTOR, AND DATES):

Please list all previous surgeries in the space provided below:

Major Illnesses:

How many pregnancies and list dates of each:

Miscarriages:

Please list all medications you are currently taking (please include dosages and when you started the medication):

Are you currently taking any of the following medications?
Please check all boxes that apply to you.

☐ Birth control pills
☐ Hormone replacements
☐ Aspirin
☐ Plavix

FAMILY HISTORY
(Grandparents, Parents, Siblings)

What other family members are obese?
(indicate mother's/father's side of your family

_____

_____

What other family members have or have had Breast, Colon, or Prostate Cancer:

_____

_____

Cancer (specify type):

_____

_____

Diabetes:

_____

_____

Heart Attack:

_____

_____

Stroke:

_____

_____

High Blood Pressure:

_____

_____

Other problems not listed above:

SOCIAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children: _____ Number of people living in your home? _____

Education: (please check all that apply)

☐ Some school ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post Graduate

Please briefly state the feelings of your spouse or partner in regards to bariatric surgery:
_____
_____
_____

Please briefly state the feelings of your family in regards to bariatric surgery:
_____
_____
_____

Smoking History: ☐ I do not smoke ☐ I quit smoking ☐ I smoke _____ packs/day

Alcohol Consumption: ☐ None ☐ Occasional/Socially ☐ Often (specify amount per week): _____

Coffee / Caffeine Use: ☐ None **Type**: _____ Amount/day: _____

Carbonated beverages: ☐ None **Type**: _____ Amount/day: _____

Diet: ☐ None **Type**: _____

Frequent snacking: ☐ None **Type**: _____ Amount/day: _____

Physical Limitations (please check all that apply):

☐ Climbing stairs ☐ Use of public seating ☐ Caring for personal needs

☐ Playing with children ☐ Airline travel ☐ Work duties

Review of Systems

PLEASE READ THE FOLLOWING CAREFULLY AND CHECK ALL THAT APPLY

SYMPTOMS	YES	NO	COMMENTS
Frequent/severe fatigue or weakness			
Fever/chills/sweats			
Frequent/severe Headaches			
Any hx of head injury w/ loss of consciousness			
Eyeglasses or contact lenses			
Visual problems that aren't correctable			
Hearing problems			
Chronic sinus congestion			
Dental problems			
Dentures			
Wheezing			
Coughing			
Breast lump, pain or discharge			
Heart murmur			
High blood pressure			
Birth control			
Infertility			
Anemia			
Any history of blood transfusion			
Bleeding tendency			
Convulsions or Seizures			
Paralysis			
Numbness or Tingling			
Memory Loss			
Depression			
Anxiety			
Mood swings			
Sleep problems			
Drug or alcohol use			
Chronic skin rash or hives			
Asthma			

Review of Systems (cont'd)

SYMPTOMS	YES	NO	COMMENTS
Hay fever			
Morning Headaches			
Difficulty breathing while lying flat			
Must prop up on multiple pillows to sleep			
Excessive snoring			
Feeling like you aren't getting enough sleep			
Falling asleep during daytime activities/driving			
Waking up at night short of breath			
Stop breathing during sleep			
Frequent urination at night			
Delayed healing of sores or wounds			
Do you take blood pressure medications			
Chest pain at rest			
Chest pain on exertion			
Shortness of breath			
Discoloration of lower leg			
Swelling in feet			
Pain in joints			
Numbness/pain going down one or both legs			
Heartburn after eating			
Fluid coming up in throat when lying flat			
Food getting stuck when swallowing			
Skipping menstrual cycles			
Heavy or abnormal menstrual cycles			
Irregular periods			
Do you take medication for cholesterol			
Do you have thyroid problems			
Do you involuntarily lose your urine			
Any history of bladder surgery			
Loose urine when sneezing/coughing			
Loose urine when bending/laughing			
Psychiatric treatment			
Hospitalization for psychiatric treatment			
Eating disorders			

DIET HISTORY

How long have you been overweight? _____

Where you overweight as a child? _____

After childbirth? _____

Please check all diet programs you have participated in and next to the program write in how long you participated in the program. ***PLEASE INCLUDE DATES***

YES	PROGRAMS	DATE (Month/Year)	YES	PROGRAMS	DATE (Month/Year)
	Diet medications			Virginia Mason Clinic	
	Pritikin Diet			Mayo Clinic	
	Slimfast			TOPS	
	Low Calorie Diet			Rader Institute	
	Subliminal Tapes			Hypnosis	
	Physician Supervised Diet			Optifast	
	High Protein			Airforce Diet	
	Weight Watchers			Diet Center	
	Herbal Life			Self Imposed Fasts	
	Medifast			Cabrini Eating Disorder	
	Living Well Lady			Magazine Diets	
	Toopfast			Liquid Protein	
	Jenny Craig			Nutri-System	
	Overeaters Anonymous			HMR	
	Numerous Book Diets			Over the counter preparations	
	LA weight loss center			Any other not programs not listed	

Please check any of the medications below that you have been prescribed and to the right please write in how long you were on the medications.

☐ Fen-Phen _____
☐ Xenical _____
☐ Tenuate _____
☐ Ionamin _____
☐ Redux _____
☐ Pondimin _____
☐ Sanorex _____
☐ Other: _____

Please list any over-the-counter diet medications you have tried.

How did any of the above fail to meet your needs?

What is the most weight you have lost at one time?

At what age did you begin dieting?

Check All That Apply

Has your primary physician or any physician diagnosed you with any of the following diseases?

- ☐ Hypertension
- ☐ Diabetes
- ☐ Obstructive sleep apnea
- ☐ High Triglycerides
- ☐ High Cholesterol
- ☐ Arthritis
  - ☐ Knees
  - ☐ Ankles
  - ☐ Hips
- ☐ GERD (gastroesophageal reflux disease)
- ☐ Depression
- ☐ Degenerative joint disease
- ☐ Venous Stasis Disease
- ☐ Lumbar Disc Disease
- ☐ Polycystic Ovarian Syndrome
- ☐ Planter Fasciitis
- ☐ Urinary Stress Incontinence
- ☐ Insulin Resistance syndrome
- ☐ Syndrome X
- ☐ Amenorrhea
- ☐ Asthma
- ☐ Pseudotumor Cerebri
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Chronic leg ulcers
- ☐ Chronic skin disorders or infections
- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Colon cancer
- ☐ Gestational Diabetes

Please list any and all physicians that are involved in your medical care:

(Please list both first and last name, phone number, and address)

***WHEN LISTING YOUR PHYSICIANS BE SURE TO INCLUDE HOW MANY YEARS THEY HAVE TREATING YOU. THIS INFORMATION IS NEEDED AS PART OF THE INSURANCE APPROVAL PROCESS.**

*Primary Care Physician:

Physician's Name: _____

Physician's Address: _____

_____

Physician's Telephone #:_____

Years Treated by Your Physician: _____

*Other Attending Physicians:

Cardiologist's Name: _____

Please provide us with the following:

- Date of Most Recent Visit with Cardiologist_____
- Date of Last Stress Test (Nuclear or Treadmill)_____

_____ _____ _____

Doctor's Initials (verifying form reviewed) Date Time